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ABSTRACT

In May 2001, former Surgeon General David Satcher released the first national suicide prevention strategy, "The National Strategy for Suicide Prevention: Goals and Objectives for Action." Successful implementation of this plan requires comprehensive support and collaboration from individuals and organizations within the local community and the public at large. Perhaps nowhere is participation more critical than on the college or university campus, for over the last 60 years the suicide rate among adolescents has tripled, making it the second leading cause of death among college-age students. As a follow-up to the "National Strategy," a panel of leading experts from various disciplines convened to participate in a roundtable discussion addressing the significant impact of suicide on college and university campuses and the urgent need for intervention. The overall objectives were to gain a more thorough understanding about the risk factors and conditions that contribute to suicidal ideation and suicidal behavior among college students and to establish a set of strategies that can be implemented to enhance intervention and ultimately reduce the rate of suicide, suicide attempts, and related behaviors among college students. The information in this report reflects the conclusions and recommendations of the national experts who attended the roundtable. (GCP)

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ED 471 674

SAFEGUARDING YOUR STUDENTS AGAINST SUICIDE

Expanding the Safety Net:

Proceedings from an Expert Panel on Vulnerability, Depressive Symptoms, and Suicidal Behavior on College Campuses

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EXECUTIVE SUMMARY

In May 2001, former Surgeon General David Satcher, MD, PhD, released the first national suicide prevention strategy, *The National Strategy for Suicide Prevention: Goals and Objectives for Action.*[1] As a follow-up, a panel of leading experts convened to participate in a roundtable discussion, *Expanding the Safety Net: A Roundtable on Vulnerability, Depressive Symptoms, and Suicidal Behavior on College Campuses*, specifically to address the urgent and significant issue of suicide on the college campus.

Over the past 60 years, the overall rate of suicide among adolescents has tripled, making it the third leading cause of death among 15- to 24-year-olds and the second leading cause of death among college-age students.[2,3] Research estimates project 1088 suicides to occur on college campuses each year.[4,5] Data from a recent survey conducted by the American College Health Association (ACHA) show that 9.5% of the 16,000 students surveyed have seriously contemplated suicide and 1.5% have made a suicide attempt.[6] Depression, sadness, and hopelessness seem to play a major role when a student feels suicidal, although there are a number of additional risk factors related to college-student suicide.

While suicidal behaviors are often evident in a wide cross-section of people, there is general agreement that there are two distinct groups of students on campus who may be at higher risk for suicide: students who have pre-existing mental health conditions when they enter college and students who develop mental health problems during the college years. Age, gender, ethnicity, and treatment status all have an impact on the risk profile.

Essential services for addressing suicidal behaviors on campus include: screening program(s); targeted educational programs for faculty, coaches, clergy, and student/resident advisors; broad-based, campus-wide public education; educational programs and materials for parents and families; on-site counseling center services with appropriately trained personnel; on-site medical services; stress-reduction programs; non-clinical student support networks; off-campus referrals; emergency services; postvention programs, and medical leave policies.

There are several steps that college administrators can take to establish a comprehensive, collaborative program aimed at the reduction of suicidal ideation and suicidal behaviors on their campuses. One of the first is to take a personal inventory of exactly what mental health services your institution offers. A checklist is provided to assess these services, based on the essential services as identified by experts at the roundtable. Results will help determine subsequent steps that may need to be taken.

We are faced with a crisis that demands personal attention, as well as political and community advocacy. The mental health of our college campuses depends on coordinated and collaborative efforts and services. Only through subsequent meetings and continued efforts aimed at identifying specific, collaborative programs, can we continue the work that has been started by this expert panel.

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1. US Department of Health and Human Services (2001): National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville, MD: Public Health Service (Document No. SMA 3517). www.mentalhealth.org/suicideprevention. Web site, accessed May 3, 2001. 2. Vastag B. Suicide prevention plan calls for physicians' help. *JAMA*. 2001;285(11):2701-2703. 3. Centers for Disease Control. National Center for Chronic Disease and Health Promotion, Youth Risk Surveillance: National College Health Risk Survey, 1995. 4. Silverman M, et al. The Big Ten Student Suicide Study: A Ten-Year Study of Suicides on Midwestern University Campuses. *Suicide and Life Threatening Behavior*. 1997;27(3), 285-307. 5. US Department of Education, National Center for Education Statistics. *Digest of Education Statistics: Postsecondary Education*. www.nces.ed.gov. Web site, accessed October 4, 2001. 6. American College Health Association. National College Health Assessment: Reference Group Report, Spring 2000. Baltimore: American College Health Association:2001.

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INTRODUCTION

In May 2001, former Surgeon General David Satcher, MD, PhD, released the first national suicide prevention strategy, *The National Strategy for Suicide Prevention: Goals and Objectives for Action.*[1] This broad-based community-health initiative aims to:

- prevent premature deaths due to suicide
- reduce the rates of other suicidal behaviors
- reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends
- promote opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities

Successful implementation of this plan requires comprehensive support and collaboration from individuals and organizations within the local community and the public at large. Perhaps nowhere is participation more critical than on the college or university campus, for over the past 60 years, the overall rate of suicide among adolescents has tripled, making it the third leading cause of death among 15- to 24-year-olds and the second leading cause of death among college-age students.[2,3] Taking the generally accepted rate of 7.5 suicides for every 100,000 students on the college campus[4] and applying that to the total 14.5 million US students enrolled (includes students of all ages enrolled in 2- and 4-year degree-granting institutions),[5] would result in an anticipated 1088 suicides on college campuses per year.

As a follow-up to the *National Strategy*, a panel of leading experts from various disciplines, including clinical psychology, developmental psychology, and psychiatry, as well as epidemiology, suicidology, sociology, and public health, convened to participate in a roundtable discussion, *Expanding the Safety Net: A Roundtable on Vulnerability, Depressive Symptoms, and Suicidal Behavior on College Campuses.* Co-sponsored by the National Mental Health Association (NMHA) and the Jed Foundation, this roundtable was organized to address the significant impact of suicide on college and university campuses and the urgent need for intervention. The overall objectives were to gain a more thorough understanding about the risk factors and conditions that contribute to suicidal ideation and suicidal behavior among college students and to establish a set of strategies that can be implemented to enhance intervention and ultimately reduce the rate of suicide, suicide attempts, and related behaviors among college students.

The information that follows reflects the conclusions and recommendations of the national experts who attended this roundtable. The focus of this discussion was centered around the 18- to 24-year-old student living on or near the campus; part-time/night students in their 30s were not specifically addressed. The information provided here is designed to help you assess the current status and needs of your institution, as you ask yourself and your colleagues, "What safeguards do we have in place against suicide?"

THE FACTS AND FIGURES ARE STAGGERING

While we may tend to look upon the college years as a time of growth and opportunity, these years are also replete with the stress that often accompanies such a major developmental milestone.[6] The stigma that surrounds mental health disorders in general, and suicide in particular undoubtedly distorts society's full understanding of the extent of suicidal ideation and suicidal behaviors on the college campus. Table 1 presents a general overview of suicide and mental illness as seen among college-aged students.

TABLE 1

Overview of suicide and mental illness among college-aged students.[3]

- Suicide is the second leading cause of death among 20- to 24-year-olds
- More teenagers and young adults die from suicide than from all medical illnesses combined
- The suicide rate peaks among young adults (ages 20 to 24)
- One in 12 US college students makes a suicide plan
- Clinical depression often first appears in adolescence
- The vast majority of young adults aged 18 and older who are diagnosed with depression do not receive appropriate or even any treatment at all

More specifically, research has shown the overall rate of completed suicides among college and university students to be approximately 7.5 per 100,000 (Table 2).[4,7]

TABLE 2

Suicide rates of college students (per 100,000).[7]

Age	Women	Men	Total
17-19	1.2	5.7	3.4
20-24	4.5	9.0	7.1
All students*	4.5	10.0	7.5

*Includes students ranging in age from 17 to 49.

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Data from a recent survey conducted by the American College Health Association (ACHA) provide greater insight into the nature of suicide on campus.[8] These data encompass 16,000 students from 28 college campuses across the nation. As noted by the experts, these data are consistent with the 1995 CDC data from the National College Health Risk Behavior Surveillance Study.[3] Among the students studied by the ACHA, 9.5% have seriously contemplated suicide and 1.5% have made a suicide attempt (Table 3).[8]

TABLE 3

Suicide on campus (ACHA).[8]

	Women(%)	Men(%)	Total(%)
Very sad*	55.5	41.9	50.3
Hopeless*	36.5	28.3	33.4
So depressed, could not function*	24.0	19.0	22.1
Seriously considered suicide†	9.9	9.7	9.5
Attempted suicide†	1.4	1.6	1.5

* 3 or more times in the previous year.
† 1 or more times in the previous year.

The role of depression, sadness, and hopelessness.

Fifty percent of the students who participated in the ACHA survey reported feeling sad, 33% reported feeling hopeless, and 22% felt so depressed that they could not function, 3 or more times in the previous year. Yet, among the total population, only 6.2% of men and 12.8 % of women had been diagnosed with depression, with 2.3% and 4.8%, respectively, having been diagnosed within the prior 12 months. This tells us that there may be a group of students who are not being diagnosed and who may be overlooked when it comes to receiving adequate treatment and supportive services. Furthermore, among those students who seriously considered suicide, 94.8% reported that they felt so sad that they could not function (at least one time in the previous year), and 94.4% reported feelings of hopelessness. Conversely, only 23.8% of students who reported feeling hopeless, and only 33.4% of those who reported feeling depressed seriously considered suicide. So, while feeling depressed and not being able to function or feeling hopeless does not necessarily mean that someone is seriously considering suicide, feeling suicidal often does include feelings of depression and hopelessness.

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WHO IS AT RISK?

While suicidal behaviors are often evident in a wide cross-section of people, there is general agreement among mental health leaders that there are two distinct groups of students on campus who may be at higher risk for suicide (Table 4). These are:

- Students who have pre-existing mental health conditions when they enter college
- Students who develop mental health problems during the college years

For those students who enter college with a history of mental health problems, it is imperative that the college provides the tools that will enable these students to succeed in their new campus environment. The college campus mental health center cannot be the sole provider of support for these students. Indeed, college administrators and counselors must work more closely with the students, their families, their previous school systems, and other healthcare providers in order to ensure a more successful transfer of care. For example, any students who have received a diagnosis of depression or are known substance abusers (independent risk factors for suicide and suicidal behaviors) must continue with their prescribed therapeutic regimens, whether it be medication, counseling, or both, in order to preserve continuity of treatment and to ensure therapeutic success and an increased likelihood of success in college.

Furthermore, the nature of the campus environment itself may serve to exacerbate any existing symptoms or engender the expression of emotional or behavioral disorders in those students who may be predisposed to mental illness.[3] Consequently, students and their parents should consider the campus environment when deciding on a school. For example, the student who is socially shy may feel more comfortable at a smaller school that has a heightened sense of community. In general, schools should try to avoid a cold, impersonal atmosphere where students feel they are treated as "just a number." This type of environment may only serve to unwittingly aggravate any feelings of inadequacy and lack of self worth.

Students entering college are often leaving home for the first time, separating from family and friends, and entering into a new, unknown environment that may be extremely different from that with which they are familiar, and these are significant developmental issues. Continuing students often feel increased academic and social pressures as they advance through school. Campuses that provide accessible resources or student services for academic assistance can help ameliorate these feelings of failure or alienation.

Students who develop mental health problems once they are in college need to know what support services are available to them. Once they start to feel that they are having difficulty, or are not performing as well as they previously had, they need to know where and from whom help is available. These students may be academically driven to succeed beyond what may be possible. They may be overachievers who cannot tolerate even the slightest hint of failure, they may have a family history of mental illness, or they may not have adequate coping skills to adjust to new demands and expectations. In any case, campus personnel who are close to the students, such as student advisors, resident advisors, faculty, and coaches, need to be informed about what to look for, as well as how to advise students on where to go for help.

TABLE 4

Table 4. Who is at a higher risk for suicidal ideation and suicide attempts on campus?[8]

There are two distinct groups on campus:

- Students with pre-existing mental health conditions
- Students who develop mental health problems during the college years

Within these two groups:

- Students under the age of 21
- Males
- Asians and Hispanics
- Students currently receiving treatment

The data from the ACHA also point to some trends in suicidal ideation and suicidal attempts in relation to age, gender, ethnicity, and treatment status[8]:

Age.

More students under 21 seriously considered (10.2%) or attempted (1.5%) suicide compared with those over the age of 22 (8.2% and 1.4%, respectively).[8]

Gender.

While more females (6.8%) than males (5.4%) report having considered suicide one or two times, more males (3.3%) than females (3.1%) report having considered it three or four times.[8] While this difference may seem slight, it is nevertheless an important point when considering that more males than females are completing suicide.

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Ethnicity.

More whites than African Americans, Asians, and Hispanics report being depressed, yet more Asians and Hispanics (although not African Americans) than whites report seriously considering suicide.[8] As noted by the experts, however, only 5%-10% of African-American students will use on-campus counseling services due to fear of stigma and parent/teacher discovery. Suicidal ideation and suicide attempts may therefore be underreported in this population. Consequently, universities must be more diligent in reaching out to African-American students on campus who may be in need of services.

Treatment status.

While the number of students receiving mental health treatment is significantly lower than the total that reports having experienced depression, a high proportion of those in treatment (44.6%) have seriously considered suicide.[8] This means that campus-counseling centers may be dealing with students with suicidal ideation and potential suicide attempts in almost 1 out of every 2 cases they see—an insurmountable number of cases to handle without adequate resources. There should also be concern about those students who acknowledge depression, yet are not in treatment. There is, therefore, a critical need for counselors and others to receive special training and education specifically directed at suicidal ideation, suicidal behaviors, and suicide prevention. This will help to ensure that students who are in treatment are receiving adequate and appropriate therapy, as well as to increase awareness and identification of those who are not in treatment, but may need to be.

WHAT CAN WE DO?

The complex problem of suicide and suicidal behaviors on campus demands a multifaceted, collaborative approach. We cannot expect to accomplish the goals set forth in the *National Strategy* by leaving it solely up to the campus counselors and/or mental health centers. College administrators must work to ensure that all elements of the campus and the entire community are working together. Table 5 lists the services that are essential to addressing the morbidity and mortality associated with campus suicidal behaviors.

TABLE 5

Essential services for addressing suicidal behaviors on campus.

- Screening program(s)
- Targeted educational programs for faculty, coaches, clergy, and student/resident advisors
- Broad-based, campus-wide public education
- Educational programs and materials for parents and families
- On-site counseling center with appropriately trained providers
- On-site medical services
- Stress-reduction programs
- Non-clinical student support network
- Off-campus referrals, if available
- Emergency services
- Postvention programs
- Medical leave policies

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Screening program(s).

There are many different strategies for developing a screening system for case identification. Specific, highly sensitive, brief questionnaires are available. Those that are preferable probe for the presence of signs, symptoms, and salient behaviors that are pertinent to establishing a diagnosis or assessing the risk for suicide and suicidal behaviors. Screening can result in earlier detection and improved treatment. It is important to note, however, that screening alone does not provide a diagnosis and should be followed by referrals to mental health services and a full evaluation by a qualified mental health provider if warranted.

Targeted educational programs for faculty, coaches, clergy, and student/resident advisors.

Coordinated efforts must be made to educate and train those who have daily contact with students. Educational and counseling programs must be in place in order to train these personnel to recognize the signs and symptoms of at-risk behaviors, which might be signs of depression or suicidal thoughts. These include, but are not limited to, abusing drugs and/or alcohol, and behaving impulsively, immaturely, and in a physically reckless manner. Furthermore, once identification has been made, university personnel need to know how they can access services and support for students. They must be aware of the programs and services that exist in and around the campus and where they can turn to for the support that students need.

Broad-based, campus-wide public education.

While cost-effective for campuses to implement, public education on campus reaps significant benefits. Through public education, the stigma associated with mental health disorders and suicide can be addressed right at the source. Perhaps campuses can enlist the support of some high-profile student "heroes," such as athletes, actors/actresses, musicians, etc., who have first-hand experience with depression, anxiety, and suicide. These people can not only educate, but can also help to reduce the pervasive stigma. Additionally, students can be educated in general about signs and symptoms of mental health disorders and, more specifically, suicide and suicidal behaviors. They are often more adept at noticing changes and detecting trouble in their peers than are many professionals who may merely be casual observers.

Educational programs and materials for parents and families.

Often enough, families may look upon college as a developmental "new beginning," thinking that any troublesome behaviors may disappear with a new start. Educational programs and materials for parents and families can help to dispel this and other myths that surround the college experience. Campuses can also utilize this forum to inform parents about any mental health services that they offer on and off the campus, enabling parents to ensure their children are provided with appropriate and adequate support.

On-site counseling center.

At the very minimum, the campus mental health center must have appropriately trained and skilled interviewers and diagnosticians who can assess and triage the students who come in seeking help, as well as certified therapists. Ideally, centers should also include an emergency, after-hours, on-call service, immediate access to a hospital emergency unit complete with an attending psychiatrist, and ready access to a psychiatric inpatient unit.[3] Student counseling services cannot be the only resource or the last resort for students; we must broaden our base and enlist additional support from other resources in the community.

On-site medical services.

As we know, depression and suicidal behaviors often co-exist. Great strides have recently been made in the pharmacologic treatment of mental health disorders. Newer medications have been developed that have proven to be successful in the treatment of depression, as well as other mental health disorders, and additional agents are becoming available on a regular basis. It is therefore crucial that medical personnel with the authority to prescribe these medications be available on campus. In addition, psychotherapies such as cognitive behavior therapy (CBT), interpersonal therapy (IT), and other methods have been shown to be highly effective in the treatment of anxiety and depression.

Stress-reduction programs.

College life can indeed be stressful. There may be academic stress, social stress, and financial stress, all of which may be exacerbated by lack of sleep or an inadequate or improper diet. Students need to have a resource to help them manage and reduce these stressors, so that they do not build up and become too burdensome and ultimately, unbearable. Stress-reduction programs can be specifically targeted for those students at risk for suicide and suicidal behaviors. Other examples of programs that can help reduce the stress load on students include study-skills workshops, loss of relationships/bereavement groups, international student support groups.

Non-clinical student support networks.

Students may prefer the anonymity offered by a telephone help line or Internet site. These are useful support options that they can utilize 24 hours a day, 7 days a week. Make sure the college Web site has a link to respected mental health organizations or qualified individuals in the community who are available to provide help (www.ulifeline.org is one example of how this works). Peer-support groups should also be made available to students, who may view them as "less threatening," and consequently may feel more comfortable attending them.

Off-campus referrals.

It is important to establish a list of therapists in the community in the event that a student prefers to seek off-campus assistance. It is also important that this list of professionals be ethnically diverse. Preparing a list that includes names and addresses along with a photograph may help the student in choosing a therapist who might be a better fit, right from the start. Campus-counseling centers should strive toward making sure these connections take place. Appointment hours, fee schedules and insurance specifications should all be made available in advance.

Emergency services.

24-hour access to services must be made available. Students, faculty and other personnel must know where to go and who to call, prior to the need. If emergency services are not available on campus, make sure it is widely known which hospital/center in the community is on call to handle any campus emergencies. Phone numbers for hotlines, community emergency/crisis intervention services, and mobile support services must be made widely known and publicly displayed.

Postvention programs.

The aftermath of a death or near-death on campus is a critical time for everyone. While prevention must be our goal, intervention after the crisis has occurred (known as postvention) is equally as important. A crisis-intervention or emergency plan should be created to enlist the help of all necessary professionals during this time. Make sure students are aware of the support services that will be available to help them.

Medical leave policies.

A compassionate medical leave policy is often available for students who become diagnosed with a malignancy or other life-threatening medical condition. The same should hold true for debilitating and life-threatening mental health disorders. Too often, a student is suspended after a suicide attempt, increasing the already apparent stigma associated with the action itself. As with students who recover from other medical conditions, students who have attempted suicide should be allowed to re-register and resume their education, once their symptoms have resolved and they return to a stable state.

SAFEGUARDING AGAINST SUICIDE

We have reviewed several steps that college administrators can take to establish a comprehensive, collaborative program aimed at the reduction of suicide and suicidal behaviors on their campuses. In addition, we recommend taking an inventory of exactly what mental health services your institution offers. Table 6 provides a checklist for you to use to assess these services, based on the essential services as identified by experts at the roundtable. The results of your assessment profile will provide you with guidance for the subsequent steps you may need to take.

TABLE 6

A Checklist for Your Institution.

Administrative Policies

___Yes ___ No • Do we have a mental health management plan in writing?

___Yes ___ No • Have we allocated enough financial resources to accommodate the plan and all of its components?

___Yes ___ No • Do we have a Medical Leave policy in place that includes mental health problems?

Risk-Identification Programs

___Yes ___ No • Do we have a screening program in place?

___Yes ___ No • Do we have a transitional support program in place for parents and families of incoming students who have already been diagnosed with mental health disorders?

___Yes ___ No • Have we trained our faculty, coaches, clergy, and student/resident advisors to identify students who may be at risk for suicide and/or suicidal behaviors?

___Yes ___ No • Have we educated our students so that they are able to identify at-risk behaviors within themselves and among their peers?

On-Campus Support Services

___Yes ___ No • Do we have an on-site mental health services center?

___Yes ___ No • Have we hired providers who are appropriately trained to handle suicidal clients? If not, are we willing to train them?

___Yes ___ No • Do we have an on-site medical center with personnel who can prescribe the appropriate psychotropic agents?

___Yes ___ No • Do we have a 24-hour emergency service that is accessible to students?

___Yes ___ No • Do we have a crisis-management plan in place in the event of a suicide or other trauma on campus?

___Yes ___ No • Do we provide students with support programs (social, academic, etc.)?

___Yes ___ No • Have we made our students and faculty aware of exactly what services are offered on campus and in the community?

___Yes ___ No • Have we publicized the names and numbers of on-campus and off-site support providers?

Community-Based Support Services

___Yes ___ No • Do we have working relationships with community mental health providers to ensure appropriate off-site referrals? Do we know their appointment hours and fees? Have we arranged for a sliding scale? Do they accept insurance?

___Yes ___ No • Have we identified which hospital/center in the community is on call to handle any campus emergencies?

___Yes ___ No • Does our university Web site offer links to mental health information and services?

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WHERE DO WE GO FROM HERE?

We are faced with a crisis that demands personal attention, as well as political and community advocacy. The mental health of our college campuses depends on coordinated and collaborative efforts and services: College administrators must take action now to safeguard their students. Campus communities must take action now to reduce the number of lives lost each year. Parents and families must implore universities to better understand their children and provide appropriate and adequate support services. Consequently, university funding must reflect all of these needs, in an effort to truly expand the safety net and safeguard our students against suicide.

Our current task is to take the information presented here and identify comprehensive initiatives that can be easily implemented. Only through subsequent meetings and continued efforts aimed at identifying specific, collaborative programs, can we continue the work that has been started by this expert panel.

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